

# The vicissitudes of the recovery construct; or, the challenge of taking “subjective experience” seriously

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“Professional and scientific communities have not sufficiently appreciated the subjective experiences of people with severe mental illness, and their ability to recover from the debilitating effects of their illness”, state Bellack and Drapalski. Their paper makes an important contribution to the growing body of research that is committed to countering erroneous assumptions regarding outcomes in people diagnosed with severe mental illness.

The ongoing scientific and philosophical debates over how to conceptualize and operationalize “recovery” (1-4) mean that this commentary could move in a number of directions. I have chosen to push the authors harder vis-à-vis certain assumptions embedded within their argument. While they state that they endorse the importance of service users’ “subjective experience”, their paper ultimately reinstalls orthodox psychological formulations grounded in traditional models of objectivity, reliability and validity. They claim that “the consumer model of recovery” employs “vague constructs that have not been objectively defined”, and they emphasize the need for “more objective measures of course of illness and community functioning that are viewed as relevant by scientists, clinicians, family members, and legislators”. Such claims end up side-stepping the

challenge that the “consumer model of recovery” (an umbrella term encompassing several distinct formulations) has posed to the way in which key psychiatric constructs – e.g., “course of illness”, “symptoms”, “community functioning” – are defined and operationalized.

This consumer model, rather than being hampered by “vagueness” in its use of constructs, poses challenging questions to psychiatry: its commitment to taking seriously the phenomenological richness and social constitution of subjective experience entails rethinking traditional ways of defining and measuring well-being and illness. Bellack and Drapalski impose a distinction between the potential “practical and conceptual implications” of recovery (which include “productive activity like work or school” and “improved social relationships”) and the “subjective well-being of consumers” (which is implicitly less valorized). In contrast, some of the most incisive thinking regarding recovery challenges such a distinction, by demonstrating how subjective well-being is itself *constituted through and built upon* sustaining and equitable social relations (5). The consumer model of recovery, far from turning away from the investigation of “practical and conceptual implications” that lie beyond issues of individual well-being, has been at the forefront of developing more nuanced accounts of empowerment that attend to transformation of the collective, as well as of the individual consumer. These

accounts imply not only that individual agency and self-efficacy are constituted through social relations; they also mean that the analytical frame through which we both understand and seek to transform agency and self-efficacy needs fundamentally to attend to social relations, and the inequalities of power that so frequently characterize them. Tew et al’s (6) recent review of the role of social factors in enabling or impeding recovery featured “self-efficacy” as only one of a much wider range of important elements that included social identities, social inclusion and community development.

Bellack and Drapalski are not alone in resorting to familiar constructs such as self-efficacy at the very moment of engagement with new paradigms (here, consumer models of recovery). This is an indication, I believe, of the challenges to psychiatric epistemologies and methods that emerge when conventional researchers engage with the thinking and methods deriving from the service user movement (7). There are, indeed, ongoing and unresolved debates concerning the extent to which conventional ways of measuring outcomes in psychiatry (e.g., through the use of standard psychological constructs, and the development and use of scales) are commensurable with the epistemologies underlying models developed by consumers.

One creative response to this dilemma has been the development of a new way of constructing scales, one that attempts seriously to address consumers’ “subjective

tive experience”, rather than simply relying on clinicians’ definition of a “good outcome”. Bellack and Drapalski describe how the iterative development of their MARS scale was led by six clinical scientists, who supplemented their work through interviews with six independent experts and a panel of consumers. While consultation with consumers is a welcome advance on *no* consultation with consumers, such a model retains the familiar balance of power, whereby consumers’ knowledge regarding recovery is positioned as far less “expert” than that of the clinical scientists and “independent experts”. Contrast this with the consumer-led model to develop outcome measures described by Rose et al (8), which has been used successfully to develop outcome measures for cognitive-behavioral therapy in psychosis (9) and in assessments of continuity of care (10). This model develops outcome measures entirely from the perspective of mental health service users, and is premised on the argument that “it is mental health service users who know from the inside what treatments and services benefit them and which are detrimental” (8).

Bellack and Drapalski would no doubt disagree that the development of outcome measures for recovery ought to follow such a route, given their argument that these measures must also be “viewed as relevant by scientists, clinicians, family members and legislators”. And this leads us to the nub of the issue. Bellack and Drapalski wish to move the recovery model away from “political decisions” (which characterize the consumer movement) and towards “empirical evidence of the validity of the model” (which characterizes the practice of science). Rose al’s alternative method for developing outcome measures demonstrates that this is a false divide: *all* empirical evidence regarding the validity of the recovery model will be inflected by “political decisions” regarding whose perspectives count in adjudicating a good outcome.

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